

Case Number:	CM13-0058089		
Date Assigned:	12/30/2013	Date of Injury:	08/25/2010
Decision Date:	05/08/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 60 year old male who was injured on 08/25/2010. The mechanism of injury is unknown. Prior treatment history has included the patient is status post lumbar fusion on 07/13/2012. He has had percutaneous spinal cord stimulator insertion on 12/31/2013. He has had a poor response to injections and failed therapy and/or chiropractic treatment. He has received a TENS unit. Medications include: 1. Cymbalta 2. Flexeril 3. Amitriptyline 4. Celebrex 5. Cialis 6. Percocet Diagnostic studies reviewed include: MRI of the right knee dated 09/24/2010: 1) there is moderate marrow edema in association with chondromalacia involving the superior medial aspect of the patella and more diffuse edema in the peripheral aspect of the medial femoral condyle and more regionally located posteromedial femoral condyle towards the intercondylar notch. 2) Moderate knee joint effusion. 3) Infrapatellar bursitis. 4) Increased signal in the anterior horn of the lateral meniscus likely reflecting adjacent structures. MRI of the lumbar spine dated 02/23/2011 with the following conclusion: 1) Compression fracture of L1 vertebral body. 2) L1-2 1-2 mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing. 3) L2-3 Mild neural foraminal narrowing secondary to 203 mm posterior disc bulge and facet joint hypertrophy. 4) L3-4 mild bilateral neural foraminal narrowing secondary to 1-2 mm posterior disc bulge and facet joint hypertrophy. 5) L4-5 severe bilateral neural foraminal narrowing and mild central canal stenosis secondary to Grade 1 anterolisthesis and facet joint hypertrophy. PR-2 dated 10/09/2013 documented the patient to have complaints of pain that is located on his lower back and radiates to bilateral legs. Patient states his pain is stabbing, burning, and numbness, aching and twisting and constant. Patient states pain medications and lying down alleviates his pain. Standing, walking, bending, lifting and twisting aggravate his pain. His pain level is 4-5/10/ Patient states he walks up to a block and aggravates severely. He takes Percocet 10/325 mg po tid and amitriptyline 100 mg po qhs with functional improvement.

He states he takes his Celebrex 200 mg po bid with improved inflammation. He states he gets 60-70% pain relief with current pain medication. Objective findings on exam revealed the patient had slowed ambulation, waddling gait, severe pain with lumbar extension and flexion and lateral bending. There was positive SLR bilaterally. Diagnoses: 1. Lumbar radiculopathy 2. Post-laminectomy pain syndrome 3. Lumbar spondylosis without myelopathy. Treatment Plan: Options of trial of spinal cord stimulation was discussed with the patient and the patient agreed to proceed. Patient was approved for psych evaluation prior to SCS trial. Will continue amitriptyline, Celebrex, omeprazole and MS Contin 15 mg. PR-2 dated 01/23/2014 documented the patient in for follow up after SCS trial on 12/13/2013. Patient states he gets 70% pain relief with SCS trial. Patient states he was taking less pain medications with SCS trial. Patient states his pain is located in his lower back and right knee. The pain radiates to bilateral lower extremities with the same features. Patient states that without pain medication pain level would be 8/10. Patient states that with pain medications his level is 6/10. Patient states 50% pain relief with current pain medications and no side effects. Objective findings on exam reveal slowed ambulation, waddling gait, severe pain with lumbar extension and flexion and lateral bending. Positive SLR bilaterally 30-45 degrees. Moderate bilateral tenderness to palpation lumbar musculature with positive twitch response.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

PURCHASE OF ELECTRODES PACK TWO TIMES TWO #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-115.

Decision rationale: According to the CA MTUS, TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions: Neuropathic pain, Phantom limb pain and CRPS II, spasticity, and multiple sclerosis. The medical records do not demonstrate the patient has any of these conditions. Furthermore, the patient has a TENS unit however, the medical records do not document any subjective report pain relief, improved function and reduction of medication use as a result of TENS use. Review of the records indicates that the patient is being considered for a spinal cord stimulator, based on the subjective positive response of 70% pain reduction with spinal cord stimulator trial. In the interim, the patient continues various medications for treatment of his lumbar condition, and reported 50% pain relief with current pain medications and no side effects. In the absence of documented benefit with TENS use, in accordance with the guidelines, purchase of electrodes for a TENS unit is not medically necessary.